



**Comprehensive Community Mental Health Services
for Children and Their Families Program**

CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT

USER'S GUIDE

*Understanding the Center for Mental Health Services' (CMHS)
Comprehensive Community Mental Health Services for
Children and Their Families Program CQI Progress Report*

April 2006

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PREFACE

Since 1993, 121 programs have been funded across the country to provide needed services to children and youth with serious mental health needs and their families. We have been extremely fortunate that this federal initiative has included the ability to gather important information about service effectiveness and system development. It is because of these data that we can say “systems of care work.” And yet, there is much that we still need to do, and many areas in which we can improve.

Constantly striving for improvement is a shared goal across all of our funded communities and system partners. I am constantly impressed with the level of commitment and dedication that we have in the field of children’s mental health, and how we all strive to create effective and accountable programs. To further our efforts, we have developed a benchmarking system to guide quality improvement activities. We are asking you to help us better understand what is working well in the transformation efforts you are involved with, and how we can work together to improve services and systems. I am very excited that the Continuous Quality Improvement (CQI) Progress Report will be a collaborative effort between the Branch, our Funded Communities, our National Evaluation Team, and our Technical Assistance Partners.

The Continuous Quality Improvement (CQI) Progress Report provides specific data on key performance indicators encompassing the key principles of the Comprehensive Mental Health Services for Children and Their Families Program. The CQI Progress Report is organized into 6 Key Areas of Performance that will help us better understand how to improve:

- System Level Outcomes
- Child and Family Outcomes
- Satisfaction with Services
- Family and Youth Involvement
- Cultural and Linguistic Competency, and
- Evidenced Based Practices

It is important to emphasize that the CQI Progress Report is a tool to support communities, and we are particularly interested in identifying areas of strength. We are also invested in creating a communication structure to discuss the performance areas. Community representatives, the National Evaluation Team and the Technical Assistance Providers will work in partnership to review the information and develop and implement actions to improve services and systems. That is the key; to capitalize on areas of strength and improve areas that remain a challenge.

As always, I look forward to your comments and feedback on this process as we work together to improve the lives of children, youth and families across America.

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INTRODUCTION

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) administers the Comprehensive Community Mental Health Services for Children and Their Families Program. The Comprehensive Community Mental Health Services for Children and Their Families Program provides grants for the improvement and expansion of systems of care to meet the needs of children with serious emotional disturbances and their families. A fundamental goal of the Child, Adolescent and Family Branch of the Center for Mental Health Services is to continually improve the quality of programs and services for children and families under this important federal initiative. As part of this effort, a tool to support the continuous quality improvement of programs has been developed using data collected as part of the national evaluation of this program.

The Continuous Quality Improvement (CQI) Progress Report is designed to provide specific data on key performance indicators encompassing the principles of the Comprehensive Community Mental Health Services for Children and Their Families Program. This guide includes three sections to provide guidelines for understanding the CQI Progress report.

Part I: Purpose of the CQI Progress Report

- A. Communication Feedback Loop
- B. Oversight by the Council on Coordination and Collaboration

Part II: Understanding the CQI Report

- A. Main Components of the Report
- B. CQI Performance Indicators
- C. Setting the Benchmarks
- D. Calculating the Scoring Index.
- E. Incorporating System of Care Assessment (SOCA) Supplement

Part III: Report Dissemination

I. Purpose of the CQI Progress Report

The CQI Progress Report is a data-driven tool designed to support dialogue within communities, and between communities and federal program partners, to promote continuous quality improvement. The CQI Progress Report was intended to add value to existing communication structures in supporting program development and technical assistance planning. The practical application of the CQI Progress Report within this framework is for project directors and other local stakeholders to be better prepared to discuss technical assistance needs with technical assistance providers and for technical assistance providers to be better prepared to develop technical assistance plans for funded communities.

The CQI Progress Report and process is designed to achieve two primary goals: (1) to move the provision of technical assistance to an “evidence-based” model – that is, using data to guide technical assistance efforts, and (2) to develop an evidence-base for technical assistance planning – that is, develop evidence that data-driven technical assistance planning supports CQI. This is accomplished by incorporating performance indicators and benchmarks to identify specific areas of strengths that can be highlighted as “best practices”, and challenges that can be targeted for improvement through technical assistance or through focused attention at the local level. These areas of strengths and challenges will be discussed as part of a communication feedback loop to support technical assistance planning and resource allocation.

A. Communication Feedback Loop

Community-level representatives and federal program partners will engage in a communication feedback loop designed to discuss performance as reported on the CQI Progress Report, identify strategies to improve performance, and develop a plan to implement those strategies. This information is consistent with the approach that there be one coordinated TA plan for all communities. Participation at the community level is critical to the communication feedback loop. Individuals at the local level will be asked to provide context for their performance and to identify strengths and challenges that contributed to their performance. Federal program partners will be asked to identify strategies to improve performance and provide technical assistance to communities in carrying out those strategies.

In order to facilitate the communication feedback loop, discussion of the CQI Progress Report between local representatives and federal program partners will take place following the dissemination of the CQI Progress Report. At minimum, local project teams and stakeholders, the TA Partnership Regional Technical Assistance Coordinators (RTACs), and the National Evaluation Liaison will participate in this discussion. This process will occur during a TA Partnership technical assistance conference call.

The purpose of the technical assistance call will be to discuss community performance, to collaboratively identify strategies to improve program performance, and to identify technical assistance or other resources that are needed. The CQI Progress Report is meant to be one tool in facilitating this conversation, and local teams are encouraged to provide other sources of information that will support the CQI effort. Specifically, items to be discussed should include:

- Areas where performance exceeded expectations,
- Areas in which the community improved from the previous reporting period,
- Areas in need of improvement, and
- Strategies to improve in those areas.

The national evaluation liaison will be trained in interpreting the CQI Progress Report, and can provide technical assistance in understanding the CQI Progress Report.

B. Oversight

Oversight for the CQI Progress Report and communication process will be governed by the CQI workgroup of the Council for Coordination and Collaboration, which is comprised of representatives from the local communities and federal program partners, including technical assistance providers. This workgroup will regularly review CQI Progress Reports and technical assistance plans that incorporate quality improvement strategies in order to ensure that CQI program goals are being met.

II. Understanding the CQI Progress Report

A. Main Components of the CQI Progress Report

Understanding what is included on the CQI Progress Report is necessary to fully realize the purpose and objectives for the report. As such, the following provides a description for the main components of the report and Figure 1 provides a sample community-level CQI Progress Report.

Figure 1
Sample CQI Progress Report

COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT Community A, April 2006							
				Date Services Started:		Oct-03	
				Number Enrolled in the Descriptive Study:		3	
				Number Enrolled in the Outcome Study:		115	
			INDEX			CHANGE	
	Performance Mark ₁	Raw Score	Benchmark ₂	Max Points	Actual Points	% Change From Previous Report	Previous Performance Mark
TOTAL SITE SCORE				100.00	78.86		
System Level Outcomes							
Service Accessibility							
1. Number of children served (with descriptive data)	+	300	196				
2. Linguistic Competency Rate	✓+	99.5%	98.9%	2.06	2.06		
3. Agency Involvement Rate-Service Provision	✓	66.0%	92.9%	3.50	2.90		
4. Caregiver Satisfaction Rate-Access to Services		4.10	4.42	3.46	3.36		
5. Timeliness of Services (average days) *		20.12	10.18	3.24	1.85		
Service Quality							
6. Agency Involvement Rate-Treatment Planning	✓+	45.0%	64.1%	3.16	2.40		

- a. **CQI Progress Report Title.** Provides the name of the community represented on the report and the date the report was issued. The National Aggregate Report represents data across all communities with available data. The indicators in the report will represent

data collected through the previous quarter (December 2005 report represents data collected through September 2005).

- b. **Descriptive Information.** The date services started, and the number of families enrolled in the descriptive and outcome studies are provided for contextual information. The date services started reflects the first services provided as part of the funded system of care. The number enrolled in the descriptive study reflects the number of EDIFs submitted to the ICN as of the data download date (December 2005 report reflects EDIFs submitted through September 2005, etc.). The number enrolled in the outcome study reflects the number of baseline outcome study cases that have been submitted to the ICN as of the data download date (December 2005 report reflects EDIFs submitted through September 2005, etc.). The baseline instrument with the largest number of cases is used as the number enrolled in the outcome study.
- c. **Key Areas of Performance.** The CQI Progress report is organized according to 6 key areas of performance, including (1) System Level Outcomes, (2) Child and Family Level Outcomes, (3) Satisfaction with Services, (4) Cultural and Linguistic Competency, (5) Family and Youth Involvement, and (6) Evidence-based Practices.
- d. **Subdomain of Key Area of Performance.** Where appropriate, the key area of performance is grouped by subdomain to represent separate categories within the key area of performance.
- e. **Performance Indicators.** Within each key area of performance is a set of indicators that represent performance in that key area. For some key areas of performance indicators are grouped by subdomain to further group indicators.
- f. **Performance Mark.** This column represents how well the community is performing relative to other communities in the cohort. The symbols represent the quartile at which the raw score falls; ‘+’ represents the top quartile (75% to 100%), ‘✓+’ represents the quartile just below the top (50% to 75%), ‘✓’ represents the quartile just under the half way mark (25% to 50%), and ‘-’ represents the lowest quartile (0% to 25%).
- g. **Raw Score.** The raw score represents the raw calculation for the specific performance indicator based on available data during the reporting period.
- h. **Benchmark.** For each indicator, a benchmark is established that represents the 75th percentile across sites. Benchmarks are the established raw score that communities should attempt to exceed.
- i. **Index.** The index represents a score calculated based on the proportion of the established benchmark achieved by the raw score. “**Max points**” represent the total number of points available for the indicator. “**Actual Points**” represent the number of points assigned to the indicator based on the raw score. The proportion of the established benchmark achieved by the raw score is assigned to the Max Points to calculate the Points.
- j. **Change.** “**Percent Change from Previous Report**” represents the percent change in raw score from the previous report. This will assess the community’s ability to improve performance. “**Previous Performance Mark**” represents the quartile that was achieved on the previous report. This can be compared to the current performance mark to assess the community’s ability to improve compared to other communities in the same cohort.

- k. **Total Site Score.** The total site score represents the sum of points across all indicators included on the report (avoiding duplication). A total site score will be provided for percentile, points, max points, and the change index.

Figure 2
Sample CQI Progress Report – Domain Subtotal

Satisfaction of Services						
28. Caregiver Overall Satisfaction	3.90	4.09	3.00	2.86		
29. Youth Overall Satisfaction	3.88	3.98	3.00	2.92		
Satisfaction with Services Subtotal			6.00	5.78		

- l. **Domain Subtotal.** In addition to the total site score, each domain contains a subtotal. The subtotal represents the sum of points across indicators within the key area of performance. Subtotals will be provided for max points, actual points, and the change index (see Figure 2).

B. CQI Indicator Overview

The CQI Progress Report is organized into 6 Key Areas of Performance, to include: (1) System Level Outcomes, (2) Child and Family Outcomes, (3) Satisfaction with Services, (4) Family and Youth Involvement, (5) Cultural and Linguistic Competency, and (6) Evidence-based Practices. (**Please note:** The Evidence-based practice domain is still in development.) The CQI indicators are calculated using data collected as part of the national evaluation cross-sectional descriptive study and the longitudinal outcome study. Initially, the CQI Progress report utilizes baseline and 6-month data to generate performance indicators. As more data are collected, data from additional follow-up periods (i.e., 12-month, 18-month, etc.) will be utilized for additional comparison purposes.

Table 1 provides a description of each indicator, including the instrument and the instrument item for which the indicator was derived. See Appendix B for a list of instruments to correspond with the instrument labels in Table 1. Specific instrument items can be found in the Phase IV Instrument Package and the Phase IV Data Manual.

Table 1
Description of CQI Indicators and Data Source

Definition of Indicators		Instrument_Item
System Level Outcomes		
Service Accessibility		
1.	Number of children served with descriptive data. The total number of children who have received system of care services since the start of the grant funded program and have been enrolled in the descriptive study (i.e., have a completed EDIF).	EDIF_13a
2.	Linguistic Competency Rate. The percentage of caregivers who indicated that the provider spoke the same language or that interpreters were available to assist them	CCSP_13a

Definition of Indicators		Instrument_Item
	always (5) or most of the time (4) during the first 6 months of services.	
	3. Agency Involvement Rate-Service Provision. The percentage of caregivers who identified more than one agency involved in providing services to their child and their family during the first 6 months of services.	MSSC_7
	4. Caregiver Satisfaction Rate-Access to Services. The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring agreement with access to service statements at 6 months after service intake.	YSS-F_8 and YSS-F_9
	5. Timeliness of Services (average days). The average number of days between the assessment date and the first date of service across all cases with an EDIF.	EDIF_13 and EDIF_13a
Service Quality		
	6. Agency Involvement Rate-Treatment Planning. The percentage of cases with staff other than mental health involved in the development of the child's service plan.	EDIF_14
	7. Informal Supports Rate. The percentage of caregivers who reported receiving informal supports during the first 6 months of services.	MSSC_Q34
	8. Caregiver Satisfaction Rate-Quality of Services. The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring youth agreement with quality of service statements at 6 months after service intake.	YSS-F_Q1, YSS-F_Q4, YSS-F_Q5, YSS-F_Q7, YSS-F_Q10, YSS-F_Q11
	9. Youth Satisfaction Rate-Quality of Services. The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring youth agreement with quality of service statements at 6 months after service intake.	YSS_Q1, YSS_Q4, YSS_Q5, YSS_Q7, YSS_Q10, YSS_Q11
	10. Caregiver Satisfaction Rate- Outcomes. The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring agreement at 6 months after service intake with statements concerning the outcomes resulting from the services their child or family received.	YSS-F_Q16, YSS-F_Q17, YSS-F_Q18, YSS-F_Q19, YSS-F_Q20, YSS-F_Q21
	11. Youth Satisfaction Rate-Outcomes. The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring youth agreement at 6 months after service intake with statements concerning the outcomes resulting from the services their child or family received.	YSS_Q16, YSS_Q17, YSS_Q18, YSS_Q19, YSS_Q20, YSS_Q21
Service Appropriateness		
	12. Increase in Individualized Education Plan (IEP) Development (intake to 6 months). The percent increase in the number of cases that had an IEP at intake to the total number of cases that had an IEP at 6 months after intake, for those cases with complete data at intake and at 6 months.	EQ-R_5 and EQR_5_2
	13. Substance Use Treatment Rate. The percentage of caregivers who reported that their child had a problem with substance abuse and reported that the child received at least one service during the first 6 months of services that was related to the child's substance abuse problem.	MSSC_9, MSSC_10c – MSSC_34c
Child and Family Outcomes		
Caregiver Report		
Child Level		
	14. School Enrollment Rate. The percentage of caregivers who reported that their child attended school at any time during the first 6 months after service intake,	EQ-R_1

Definition of Indicators		Instrument_Item
	excluding caregivers who reported that the youth graduated from high school or obtained a GED.	
	15. School Attendance Rate. The percentage of caregivers who report that their child attended school at least 80% of the time in the first 6 months after service intake.	EQ_2 and EQ_3a
	16. School Performance Improvement Rate (intake to 6 months). The percentage of cases where the youth's grade point average improved during the first 6 months of services.	EQ_12
	17. Stability in Living Situation Rate. The percentage of cases where the youth lived in one living situation during the first 6 months of services.	LSQ_1 – LSQ-15
	18. Inpatient Hospitalization Days per Youth. The average number of days per youth spent in inpatient hospitalization during the first 6 months of services.	LSQ_1 – LSQ_15
	19. Suicide Attempt Reduction Rate-Caregiver Report (intake to 6 months). The percent change from intake to 6 months in the number of caregivers who reported a suicide attempt for their child in the previous 6 months, for cases with complete data at intake and 6 months. A negative raw score indicates a positive outcome (i.e., fewer suicide attempts).	CIQ-I_20b and CIQ-F_20b
	20. Emotional and Behavioral Problem Improvement Rate (intake to 6 months). The percentage of cases demonstrating improvement from intake to 6 months in emotional and behavioral total problem scores on the Child Behavior Checklist, according to the reliable change index (RCI).	CBCL 6-18
Family Level		
	21. Average Reduction in Employment Days Lost (intake to 6 months). The difference from intake to 6 months in the average number of days missed work due to child's problem for cases with complete data at intake and 6 months. A negative raw score indicates a positive outcome (i.e., fewer average days lost).	CIQ-I_13d and CIQ-F_13d
	22. Family Functioning Improvement Rate (intake to 6 months). The percent change from intake to 6 months in mean score on the family functioning scale for cases with complete data at intake and 6 months.	FLQ_1 – FLQ_10
	23. Caregiver Strain Improvement Rate (intake to 6 months). The percentage of cases demonstrating improvement from intake to 6 months in caregiver strain on the Caregiver Strain Questionnaire, according to the reliable change index (RCI).	CGSQGLOB and CGSQGLOB_2
Youth Report		
	24. Youth No Arrest Rate (intake to 6 months). The percent change from intake to 6 months in the number of youth who reported no arrests in the previous 6 months for cases with complete data at intake and 6 months.	DS-R_24 and DS-R_24b DS_R_24_2 and DS-R_24b_2
	25. Suicide Attempt Reduction Rate-Youth Report (intake to 6 months). The percent change from intake to 6 months in the number of youth who reported a suicide attempt in the previous 6 months for cases with complete data at intake and 6 months. A negative raw score indicates a positive outcome (i.e., fewer suicide attempts).	YIQ-I_17b and YIQ-F_17b
	26. Anxiety Improvement Rate (intake to 6 months). The percentage of cases demonstrating improvement from intake to 6 months in total scores on the	RCMAS

Definition of Indicators		Instrument_Item
	Revised Children's Manifest Anxiety Scales (RCMAS) according to the reliable change index (RCI).	
	27. <i>Depression Improvement Rate (intake to 6 months).</i> The percentage of cases demonstrating improvement from intake to 6 months in total scores on the Reynold's Adolescent Depression Scale (RADS) according to the reliable change index (RCI).	RADS
Satisfaction with Services		
	28. <i>Caregiver Overall Satisfaction.</i> The score for caregiver overall satisfaction is the mean score across all satisfaction items on the Youth Services Survey-Family, on a scale of 1 (strongly disagree) to 5 (strongly agree). This indicator represents a compilation of indicators 4, 8, 10, and 30.	YSS-F
	29. <i>Youth Overall Satisfaction.</i> The score for youth overall satisfaction is the mean score across all satisfaction items on the Youth Services Survey on a scale of 1 (strongly disagree) to 5 (strongly agree). This indicator represents a compilation of indicators 9, 11, 31, and 33.	YSS
Family and Youth Involvement		
	30. <i>Caregiver Satisfaction Rate-Participation.</i> The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring agreement at 6 months after service intake with statements related to caregiver participation in treatment, services and setting treatment goals.	YSS-F_2, YSS-F_3 and YSS-F_6
	31. <i>Youth Satisfaction Rate-Participation.</i> The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring agreement at 6 months after service intake with statements related to youth participation in treatment, services and setting treatment goals.	YSS_2, YSS_3 and YSS_6
	32. <i>Family Involvement Rate-Treatment Planning.</i> The percentage of cases with caregiver or other family members involved in the development of the child's service plan.	EDIF_14
	33. <i>Youth Involvement Rate-Treatment Planning.</i> The percentage of cases with the child involved in the development of the child's service plan.	EDIF_14
Cultural and Linguistic Competency		
	34. <i>Caregiver Satisfaction Rate-Cultural Competency.</i> The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring caregiver agreement at 6 months after service intake with statements related to the cultural competency of staff.	YSS-F_12, YSS-F_13, YSS-F_14, and YSS-F_15
	35. <i>Youth Satisfaction Rate-Cultural Competency.</i> The mean score across all cases on a scale of 1 (strongly disagree) to 5 (strongly agree) measuring youth agreement at 6 months after service intake with statements related to the cultural competency of staff.	YSS_12, YSS_13, YSS_14, and YSS_15

Numbers Tables (N Tables). Indicators included on the CQI Progress Report utilize data collected as part of the descriptive study (i.e., EDIFs) and the outcome study data at intake into services and at 6 months after intake into services. The number of cases included in calculating each indicator varies depending on the availability of data. The National CQI Progress Report

includes all cases with complete data for the items and data collection point(s) used in the calculation.

Community-level reports are prepared once a community has at least 20 EDIF cases, and indicators are calculated once there are at least 10 cases with complete data for the items and data collection point(s) used in the calculation. In order to determine how many cases are included in the calculation, the CQI Progress Report includes an N Table, which shows the number of cases by indicator used to calculate the site score and the national score. In addition, the N Table shows the number of communities for each indicator that have a raw score, which will be useful in interpreting the percentile. Figure 3 provides a sample N Table.

Figure 3
Sample N Table from the CQI Progress Report
N-Table

	Site *	Nat'l **	# of Sites ***
1. Number of children served	250	4552	23
2. Linguistic Competency Rate	35	585	13
3. Agency Involvement Rate-Service Provision	35	607	15
4. Caregiver Satisfaction Rate-Access to Services	35	584	14
5. Timeliness of Services (average days)	216	2165	21
6. Agency Involvement Rate-Treatment Planning	224	2295	23
7. Informal Supports Rate	34	604	15
8. Caregiver Satisfaction Rate-Quality of Services	33	584	14
9. Youth Satisfaction Rate-Quality of Services	12	391	11
10. Caregiver Satisfaction Rate- Outcomes	35	580	14
11. Youth Satisfaction Rate- Outcomes	13	390	11
12. Increase in Individualized Education Plan (IEP) Development (intake to 6 mos)	14	487	12
13. Substance Use Treatment Rate	11	76	2
14. School Enrollment Rate	35	654	15
15. School Attendance Rate (80% of the time)	36	548	14
16. School Performance Improvement Rate	25	378	11
17. Stability in Living Situation	32	655	15
18. Inpatient Hospitalization Days per Youth	31	655	15
19. Suicide Attempt Reduction Rate-Caregiver Report	33	628	15
20. Emotional and Behavioral Improvement Rate	34	588	13
21. Average Reduction in Employment Days Lost (intake to 6 mos)	36	292	11
22. Family Functioning Improvement Rate (intake to 6 mos)	39	627	13
23. Caregiver Strain Improvement Rate (intake to 6 mos)	34	621	14
24. Youth No Arrest Rate (intake to 6 mos)	16	399	12
25. Suicide Attempt Reduction Rate-Youth Report (intake to 6 mos)	16	394	12
26. Anxiety Improvement Rate (intake to 6 mos)	15	398	11
27. Depression Improvement Rate (intake to 6 mos)	15	404	11
28. Caregiver Overall Satisfaction	35	583	14
29. Youth Overall Satisfaction	15	390	11
30. Caregiver Satisfaction Rate-Participation	35	585	14
31. Youth Satisfaction Rate-Participation	15	393	11
32. Caregiver and Other Family Involvement in Service Plan	229	2335	23
33. Youth Involvement in Service Plan	228	2299	23
34. Caregiver Satisfaction Rate-Cultural Competency	36	576	14
35. Youth Satisfaction Rate-Cultural Competency	16	385	11

* Number of cases per indicator at the site level.

** Number of cases per indicator at the national level, i.e., across all cases in the national evaluation dataset.

*** Number of sites (among 25 in cohort) with a raw score reported, i.e., complete data to generate the indicator.

C. Benchmarking Methodology

Different strategies for benchmarking performance relative to established goals were considered for the CQI Progress Report, and a comparative-based approach was selected as the initial methodology. However, as more information is collected related to actual performance within similar cohorts, a criteria-based methodology (i.e., benchmarks established based on an accepted criteria) will be considered. In using a comparative-based approach, the benchmark was established by comparing actual scores across all communities and setting the benchmark at the 75th percentile. This means that within the range of scores across sites for each indicator, the benchmark will be set at a score that is greater than 75% of the data. As such, 75% of the sites with a raw score will fall below the benchmark and 25% of the sites will outperform the benchmark. The comparative-based methodology allows us to provide an objective benchmark while considering performance relative to others in the cohort.

D. Scoring Index Methodology

The CQI Progress Report provides a composite profile to help communities identify areas where they excel and areas where they are in need of improvement. The CQI Progress Report uses a Scoring Index to provide a means to interpret a community's performance at the indicator and domain level, using benchmarks that fall at the 75th percentile. The Scoring Index assigns values to each indicator, which sum to create an overall domain score and represent the maximum number of points that can be received based on performance. The Scoring Index then calculates the actual points a community receives, based on their raw score. Index points are weighted, so that greater value is placed on indicators that contribute the most to the overall domain score. The methodology for developing the Scoring Index is included in Appendix A.

The actual points that are received (i.e., "Actual Points") were calculated by taking the ratio of the raw score to the benchmark and applying the ratio to the maximum number of points allowed. For example, as shown in Figure 4, the raw score for Indicator 3 Agency Involvement Rate-Service Provision is 65.0% and the benchmark is 92.9%. The ratio of Indicator 3 to the benchmark is .699 (i.e., 65.0% / 92.9%=.699), which when applied to the maximum number of available points (i.e., 3.50) results in a total of 2.45 points received for Indicator 3.

$$\begin{array}{lcl} \text{(Raw score / Benchmark)} & & \\ \text{* Maximum Points} & = & \text{Actual Points} \quad \text{OR} \quad \frac{(65.0\% / 92.9\%)*}{3.50} = 2.45 \end{array}$$

Figure 4
Actual Points Calculation Example

	Performance Mark ₁	Raw Score	Benchmark ₂	INDEX		CHANGE	
				Max Points	Actual Points	% Change From Previous Report	Previous Performance Mark
TOTAL SITE SCORE				100.00	78.86		
System Level Outcomes							
Service Accessibility							
1. Number of children served (with descriptive data)	+	300	196				
2. Linguistic Competency Rate	✓+	99.5%	98.9%	2.06	2.06		
3. Agency Involvement Rate-Service Provision	✓	66.0%	92.9%	3.50	2.90		

E. System of Care Assessment (SOCA) Supplement

The SOCA supplement is included with the CQI Progress Report to provide additional information important in supporting CQI but reported less frequently than descriptive or outcome study data. SOCA ratings describe and assess the level of program development in relation to system-of-care principles, and are collected during site visits that occur three times over the course of the grant funding period. SOCA ratings are provided to communities following their SOCA visit, but will also be provided as a supplement to the CQI Progress Report once all communities in the cohort have been visited. The SOCA supplement will include the site rating and the cohort rating, for each completed visit. Figure 5 presents a sample of a community-level SOCA Supplement.

Figure 5
Sample SOCA Supplement

COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT Community A, December 2005						
SOCA SUPPLEMENT						
			Year 1 Visit			
	Infrastructure		Service Delivery		Combined Score	
	Site Rating	Cohort Rating	Site Rating	Cohort Rating	Site Rating	Cohort Rating
Family Focused	3.86	3.38	4.16	3.73	4.04	3.59
Individualized	3.40	2.68	3.81	3.51	3.69	3.33
Culturally Competent	2.57	2.70	3.72	3.18	3.45	3.05
Interagency	3.57	3.05	3.40	3.37	3.51	3.16
Coordinated & Collaborative	3.30	2.97	4.23	3.44	4.00	3.30
Accessible	3.88	3.00	4.08	3.73	4.05	3.58
Community Based	2.83	2.83	4.67	3.82	3.93	3.42
Least Restrictive	2.40	2.48	3.00	3.45	2.63	2.84
Evidence-based Practices	TBD	TBD	TBD	TBD	TBD	TBD

The eight principles assessed as part of the SOCA are family focused, individualized, culturally competent, interagency involvement, coordination/collaboration, accessible, community based, and least restrictive. The following describes each principle and the factors considered when rating each principle.

Family Focused: The recognition that (a) the ecological context of the family is central to the care of all children; (b) families are important contributors to, and equal partners in, any effort to serve children; and (c) all system and service processes should be planned to maximize family involvement.

Individualized: The provision of care that is expressly child-centered, that addresses the child's specific needs, and that recognizes and incorporates the child's strengths.

Culturally Competent: Sensitivity and responsiveness to, and acknowledgment of, the inherent value of differences related to race, religion, language, national origin, gender, socio-economic background, and certain community-specific characteristics.

Interagency: The involvement and partnership of core agencies from multiple child-serving agencies, including child welfare, health, juvenile justice, education, and mental health.

Coordination/Collaboration: Professionals working together in a complimentary manner to avoid duplication of services, eliminate gaps in care, and facilitate the child's and family's movement through the service system.

Accessible: The minimizing of barriers to services in terms of physical location, convenience of scheduling, and financial constraints.

Community Based: The provision of services within close geographical proximity to the intended population.

Least Restrictive: The priority that services should be delivered in settings that maximize freedom of choice and movement, and that present opportunities to interact in normative environments such as school and family.

The SOCA ratings represent the extent to which each system-of-care principle is incorporated into key components of a service delivery system. The system components are divided into two domains and ratings are provided for each. The following describes what each domain represents:

System Infrastructure: The organizational arrangements and procedural framework that support and facilitate service delivery.

Service Delivery: The activities and processes undertaken to provide services to children and families for the purpose of addressing and, to the extent possible, relieving the emotional and behavioral challenges experienced by the child.

III. Report Dissemination

Community-level and aggregate CQI Progress Reports will be developed three times per year on the same timeline as the Data Profile Reports. The community-level and aggregate CQI Progress Report will be available for download on the ICN. Communities will have access to their own report and to the aggregate report. Government Project Officers (GPOs), the TA Partnership Regional Technical Assistance Coordinators (RTACS), and the National Evaluation liaison will have access to community-level and aggregate reports. Table 2 provides the dissemination schedule.

Table 2
CQI Progress Report Dissemination Schedule

Data Download	Report Available
December	April
June	July
September	December

APPENDIX A

Scoring Index Methodology

Domain Level

The CQI Scoring Index totals 100 available points. Each of the five domains that make up the scoring index were applied a weight based on the number of indicators included in the domain. This represents the domain score. For example, the System Level Outcomes domain includes 13 of the 35 indicators included in the scoring index. Therefore, the total domain score is 37 ($13 / 35 = 37\%$ of total 100 points).

Indicator Level

In developing the CQI Progress Report, each domain was identified because it represents a key principle of the Comprehensive Mental Health Services for Children and Their Families Program for which performance will be measured. The indicators within each domain all provide a measure of that domain, but some indicators are more influential than others in explaining variations in the data that make up the domain. In order to account for this, more weight is given to the indicators that are most influential. This means that indicators with higher weights have the strongest capacity to change the overall domain score.

In order to apply statistical weights, principal component analysis (PCA) was used. PCA is a statistical method for identifying the key drivers in a multivariate model, and is a common statistical tool for developing indices (Esty, Levy, Srebotnjak & de Sherbinin, 2005). PCA was selected because it identified the indicators that were most influential in each domain and allowed statistical weights to be calculated for each indicator. The statistical weights were calculated by summing the squared coefficients across principal components and rescaling to one. The rescaled statistical weights were then applied to the total domain score to represent the maximum number of points to be received for each indicator (i.e., “Max Points”). See Esty, Levy, Srebotnjak & de Sherbinin (2005) for a description of the methodology used.

APPENDIX B
List of Instruments Included on the CQI Progress Report

Name of Instrument	Instrument Abbreviation
Record Review	
Enrollment and Descriptive Information Form	EDIF
Caregiver	
Caregiver Information Questionnaire – Baseline Caregiver	CIQ-I
Caregiver Information Questionnaire – Follow-up Caregiver	CIQ-F
Caregiver Strain Questionnaire	CGSQ
Child Behavior Checklist 6-18	CBCL 6-18
Cultural Competence and Service Provision Questionnaire	CCSP
Education Questionnaire - Revised	EQ-R
Family Life Questionnaire	FLQ
Living Situations Questionnaire	LSQ
Multi-Sector Service Contacts - Revised	MSSC
Youth Services Survey for Families	YSS-F
Youth	
Delinquency Survey - Revised	DS-R
Revised Child's Manifest Anxiety Scale	RCMAS
Reynold's Adolescent Depression Scale	RADS
Youth Information Questionnaire - Baseline	YIQ-I
Youth Information Questionnaire – Follow-up	YIQ-F
Youth Services Survey	YSS

APPENDIX C

References and Additional Readings of Interest

Brolin, M., Seaver, C., and Nalty, D. *Performance Management: Improving State Systems through Information-based Decisionmaking*. DHHS Publication No. 05-3983. Rockville, MD: Center for Substance Abuse Treatment, SAMHSA, 2004.

Children's Mental Health Benchmarking Project: Fourth Year Report (2005). Annie E. Casey Foundation, Baltimore, MD 21202.

Esty, D.C., Levey, M., Srebotnjak, T. and de Sherbinin, A. (2005). *2005 Environmental Sustainability Index: Benchmarking National Environmental Stewardship*. New Haven: Yale Center for Environmental Law & Policy.

Fountain, J., Campbell, W., Patton, T., Epstein, P. and Cohen, M. (2003). *Reporting Performance Information: Suggested Criteria for Effective Communication*, Government Accounting Standards Board (GASB) Special Report, Norwalk, CT.

Hermann, R., Palmer, H., Leff, S., Schwartz, M., Provost, S., Chan, J., Chiu, AM and Lagodmos, G. (2004). *Achieving Consensus Across Diverse Stakeholders on Quality Measures for Mental Healthcare*, Medical Care 42(12): 1246-1253.

Lichiello, P., Skariba, K. and Thompson, J. (2000). *Performance Measurement in Mental Health Final Literature Review*. Joint Legislative Audit and Review Committee, 2000 Mental Health System Performance Audit, Washington State.

Review of Performance Data Indicators and Outcomes Measurement for Mental Health Systems for Children: Final Report (2002). Joint Legislative Audit and Review Committee, Washington State.



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